FORM C40B

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Workers' Compensation
710 James Robertson Parkway, First Floor
Nashville, Tennessee 37243-0661
Toll Free: 1-800-332-2667
FAX: 615-253-1223 or 615-532-5928

REQUEST FOR BENEFIT REVIEW CONFERENCE

Failure To Complete All Items On This Form Will Cause Delay In Processing And May Result In The Form Being Returned To The Requesting Party. For assistance in completing this form call 1-800-332-2667.

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

A) DATE OF INJURY: _____

B) ASSISTANCE IS REQUESTED FOR: (Check all that apply)

Settlement Mediation: _____ Reconsideration: _____

Independent Medical Evaluation of Impairment: _____

(Employee must have reached Maximum Medical Improvement before a BRC can be scheduled.)

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C) INJURED EMPLOYEE'S NAME: _____

SSN: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

County:_____ Phone: _____

Is Employee Represented By An Attorney?

Attorney's Name: _____

Mailing Address: _____

Telephone: _____ Fax: _____

D) EMPLOYER'S NAME:

_____

Street Address: _____

City: _____ State: _____ Zip: _____

County: _____ Telephone: _____

Is Employer Represented By An Attorney?

Attorney's Name: _____

Mailing Address: _____

Telephone: _____ Fax: _____

Do Five Or More Employees Work For Employer? _____

E) WORKER'S COMPENSATION INSURANCE COMPANY NAME:

_____

Street Address: _____

City: _____ State: _____ Zip: _____

Adjuster's Name: _____ _____

Telephone: _____ Fax: _____

F) BRIEF DESCRIPTION OF INJURY:

Nature of Injury (carpal tunnel, broken arm, etc.) _____

How injury occurred (fell, lifting, driving, etc.) _____

When did *Employee* report injury to employer? _____

To Whom? _____ Person's Title: _____

How long has *Employee* worked for employer? _____

County of Injury: _____

G) MEDICAL TREATMENT:

Was *Employee* given a panel of at least three (3) doctors to chose from? _____

List the names of all doctors seen: _____

_____

Has a doctor placed *Employee* on light duty work restrictions? _____

Has a doctor taken *Employee* completely off work? _____

If answer is *yes* to either question, provide the doctor's name: _____

(Please attach all relevant records resulting from medical treatment for this injury. Failure to do so may result in resolution of your request being delayed.)

H) LITIGATION:

Has suit been filed? _____ Style of Case: _____

County: _____ Docket #: _____

Is Second Injury Fund involved? _____

If so, who is the attorney? _____

I) PERMANENT DISABILITY INFORMATION:

1) **DATE OF MAXIMUM MEDICAL IMPROVEMENT: _____**
2) **PERMANENT PARTIAL IMPAIRMENT RATING(S): _____**
3) **BODY PART (ARM, LEG, ETC): _____**

An incomplete or unsigned REQUEST FOR BENEFIT REVIEW CONFERENCE will cause a delay in processing your request. For assistance in completing this form call 1-800-332-2667

I hereby request the Department of Labor and Workforce Development to assist in any disputed workers' compensation issues related to the above-detailed injury. I also authorize the Department of Labor and Workforce Development to contact any person who has information regarding that injury. If the undersigned is the Injured Employee or the Injured Employee's legal representative, authorization is also given to the Department of Labor and Workforce Development to use the Injured Employee's social security number in any manner necessary to provide the requested assistance.

_____ _____

PRINTED NAME OF REQUESTING PARTY DATE

_____

SIGNATURE OF REQUESTNG PARTY